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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ATALIE E. MITCHELL,** **AKA ATALIE E. MCGARY** **26806 Belleza Circle** **Mission Viejo, CA 92691** **Registered Nurse License No. 686173** Respondent.	Case No. 2013 - 238 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs

2. On or about August 11, 2006, the Board of Registered Nursing issued Registered Nurse License Number 686173 to Atalie E. Mitchell, aka Atalie E. McGary (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on October 31, 2011.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Code section 118(b), provides in pertinent part, that the suspension, expiration, or forfeiture by operation of law of a license shall not deprive a board of its authority to institute or continue a disciplinary proceeding against the licensee during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

7. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

8. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct. . . .
>
> . . . .
>
> (d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.
>
> . . . .

9. Section 2762 of the Code states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

10. Section 2770.11 of the Code states:

(a) Each registered nurse who requests participation in a diversion program shall agree to cooperate with the rehabilitation program designed by a committee. Any failure to comply with the provisions of a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.

(b) If a committee determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the committee shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

11. Section 2770.12 of the Code states:

(a) After a committee in its discretion has determined that a registered nurse has successfully completed the diversion program, all records pertaining to the registered nurse's participation in the diversion program shall be purged.

(b) All board and committee records and records of a proceeding pertaining to the participation of a registered nurse in the diversion program shall be kept

confidential and are not subject to discovery or subpoena, except as specified in subdivision (b) of Section 2770.11 and subdivision (c).

(c) A registered nurse shall be deemed to have waived any rights granted by any laws and regulations relating to confidentiality of the diversion program, if he or she does any of the following:

(1) Presents information relating to any aspect of the diversion program during any stage of the disciplinary process subsequent to the filing of an accusation, statement of issues, or petition to compel an examination pursuant to Article 12.5 (commencing with Section 820) of Chapter 1. The waiver shall be limited to information necessary to verify or refute any information disclosed by the registered nurse.

(2) Files a lawsuit against the board relating to any aspect of the diversion program.

(3) Claims in defense to a disciplinary action, based on a complaint that led to the registered nurse's participation in the diversion program, that he or she was prejudiced by the length of time that passed between the alleged violation and the filing of the accusation. The waiver shall be limited to information necessary to document the length of time the registered nurse participated in the diversion program.

DRUGS

12. Buprenorphine is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(b)(1) and is a dangerous drug per Business and Professions Code section 4022.

13. Dilaudid, a brand name for hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055(b)(1)(J) and is a dangerous drug pursuant to Business and Professions Code section 4022. Dilaudid is a narcotic analgesic prescribed for the relief of moderate to severe pain.

14. Lortab, a brand name for a hydrocodone combination product, is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(3), and is a dangerous drug pursuant to Business and Professions Code section 4022.

COST RECOVERY

15. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of

the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

16. Respondent was employed as a registered nurse at Hoag Memorial Hospital (Hoag Hospital) in Newport Beach, California. On April 4, 2009, at 9:50 a.m., a hospital visitor found a needle cap with blood on it in the visitor's women's restroom sitting on top of a toilet paper dispenser at Hoag Hospital. The visitor brought the needle cap to a nursing assistant.

17. Shortly thereafter on April 4, 2009, a nursing assistant at Hoag Hospital discovered a 3cc syringe with a white cap sitting next to the chair where Respondent had been sitting while she charted. Seconds later, another registered nurse discovered a different 3cc syringe with a white cap on the other side of the chair where Respondent had been sitting. One syringe had 1cc of clear fluid and the other syringe had approximately 1.5cc of clear fluid in it. Respondent was confronted with the syringes and she admitted that they belonged to her. When asked what was in the unlabeled syringes, Respondent stated that it was saline.

18. On April 8, 2009, the Charge Nurse and a Human Resources Attorney interviewed Respondent about the incident. During the interview, Respondent admitted that one of the syringes contained saline and the other contained Digoxin. Thereafter, an internal audit and investigation ensued. The investigation revealed the following discrepancies were attributed to Respondent:

19. Patient 1: On April 2, 2009, this patient was admitted to Hoag Hospital and Respondent was assigned to his care. On April 2, 2009, at 0333 hours, charted administration on the patient's Medication Administration Record (MAR) of 1 mg of Dilaudid to this patient. That same day, at 0532 hours, Respondent charged administration of 1 mg of Dilaudid on the patient's MAR. On April 3, 2009, Respondent was not assigned to this patient and the patient did not receive any pain medications that day. On April 4, 2009, Respondent was again assigned to care for this patient. The patient was scheduled to be discharged on April 4, 2009. On April 4, 2009, at 0734 hours, Respondent removed 1 tablet of Lortab (10 mg/ 500 mg "high dose") from the Pyxis for this patient. Documentation reflected that the patient was calm and independent. On

April 4, 2009 at 0919 hours, Respondent removed 1 mg of Dilaudid from the Pyxis for this patient. Respondent documented administration of .25 mg of Dilaudid and wasted the remaining .75 mg of Dilaudid. On April 4, 2009 at 1028 hours, Respondent removed 1 mg of Dilaudid from the Pyxis for this patient. Respondent documented administration of .25 mg of Dilaudid and wasted the remaining .75 mg of Dilaudid. On April 4, 2009, the patient was questioned by Hoag Hospital staff about whether he had received pain medications. The patient denied receiving any pain medications at Hoag Hospital since his admission on April 2, 2009.

20. Patient 2: This patient was not assigned to Respondent on April 5, 2009.

a. This patient was not under Respondent's care on April 5, 2009. This patient had a physician's order for .7 mg of Dilaudid every three to four hours, as needed for pain. The patient's assigned nurse administered a dose of .7 mg of Dilaudid to this patient at 1515 hours. Less than one hour later at 1556 hours, Respondent removed 1 mg of Dilaudid from the Pyxis[1] for this patient. Respondent charted administration of .7 mg of Dilaudid to the patient and wasted the remaining .3 mg of Dilaudid. At 1822 hours, Respondent removed 1 mg of Dilaudid from the Pyxis for this patient. Respondent did not chart administration or wastage of the 1 mg of Dilaudid that she removed at 1822 hours.

b. Respondent performed a "cancelled remove" on the Pyxis for Ultram at the end of her shift. The Pyxis listed 9 units of Ultram after Respondent's cancelled remove. Shortly thereafter, the Ultram was inventoried by Hoag Hospital staff. Only 2 units of Ultram were found in the Pyxis machine.

21. Patient 5: On April 4, 2009, this patient had a physician's order for .25 mg - .5 mg of Dilaudid, every three hours as needed for severe pain. On April 4, 2009 at 1818 hours, Respondent documented administration of .25 mg of Dilaudid on this patient's MAR. Less than

[1] Pyxis is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as "wastage." This waste must be witnessed by another authorized user and is also recorded by the Pyxis machine.

two hours later at 1954 hours, Respondent documented administration of .5 mg of Dilaudid on this patient's MAR. As such, this patient received a total of .75 mg of Dilaudid, which is more than the physician had prescribed.

22. Patient 7: On April 2, 2009, this patient had a physician's order for 4 - 8 mg of Dilaudid every four hours and 1 – 2 tablets of Tylenol #3, every four hours as needed for pain. On April 2, 2009, at 1356 hours, Respondent removed 8 mg of Dilaudid for this patient from the Pyxis. Respondent failed to document administration or wastage of the 8 mg of Dilaudid. Therefore, 8 mg of Dilaudid are unaccounted for.

23. On April 15, 2009, Respondent was discharged from her position at Hoag Hospital for performance beyond scope of practice- prescribing, substandard job performance, dishonesty and not following physician orders.

24. On or about July 6, 2009, Respondent contacted the Board of Registered Nursing's MAXIMUS Diversion Program to voluntarily participate in the program. At her first DEC meeting on August 28, 2009, Respondent admitted that she diverted opiates from her employer and took it at home. Respondent also reported that she used alcohol and Vicodin for foot pain. By enrolling in MAXIMUS, Respondent agreed to abstain from the use of over-the-counter drugs, alcohol, and all other mind-altering drugs unless prescribed, agreed to submit copies of prescriptions for all prescription medications she was currently taking, agreed to attend weekly 12-step meetings, agreed to attend an aftercare program, agreed to self-report her compliance on a monthly basis, agreed to attend Nurse Support Group (NSG) meetings, agreed to contact her Clinical Case Manager (CCM) no less than once per month, and agreed to submit to urine tests to monitor drug and alcohol usage, among other terms.

25. On March 18, 2011, Respondent tested positive for Buprenorphine. On April 5, 2011, Respondent again tested positive for Buprenorphine. On April 22, 2011, Respondent was terminated from the Board's Diversion program as a public safety risk.

FIRST CAUSE FOR DISCIPLINE

(Illegally Obtaining Controlled Substances)

26. Respondent is subject to disciplinary action under section 2762(a) of the Code in that Respondent illegally obtaining or possessing controlled substances, without a prescription, while employed as a registered nurse at Hoag Hospital, as set forth in paragraphs 16-23, which are incorporated herein by reference herein.

SECOND CAUSE FOR DISCIPLINE

(Used Drugs in Dangerous Manner)

27. Respondent is subject to disciplinary action under section 2762(b) of the Code in that Respondent used controlled substances to an extent or in a manner that was dangerous to herself or others, as set forth in paragraphs 16-23, above, which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Falsify or Make Grossly Incorrect or Inconsistent Entries)

28. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2762(e) for falsifying or making grossly incorrect, inconsistent and/or unintelligible entries in the hospital records of Hoag Hospital by withdrawing medication, charging the withdrawal to patients who did not receive the drugs or for whom Respondent did not document administration or wastage of the drug as is more particularly set forth in paragraphs 16 -23 above, which are incorporated herein as though set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

29. Respondent is subject to disciplinary action under section 2761(a) of the Code in that Respondent committed unprofessional conduct, in that Respondent failed to comply with the Board's Diversion Program as she agreed to do, as set forth in paragraphs 24-25, above, which are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Violation of the Chapter)

30. Respondent is subject to disciplinary action under section 2761(d) of the Code for failure to comply with section 2770.11(a), as set forth in paragraphs 24-25, above, which are incorporated herein by reference, for failure to comply with the Board's diversion program.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 686173, issued to Atalie E. Mitchell, aka Atalie E. McGary;

2. Ordering Atalie E. Mitchell to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: OCTOBER 02, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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